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Families and Substance Abuse: The Case For A Comprehensive Approach

Joint Select Task Force on the Changing Family

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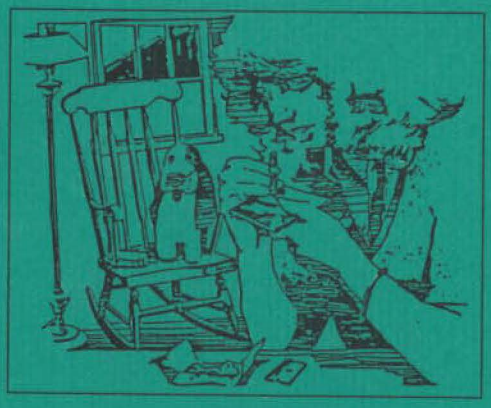

A Report By The Joint Select Task Force On The Changing Family

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FAMILIES AND SUBSTANCE ABUSE:

THE CASE FOR A COMPREHENSIVE APPROACH

A REPORT BY THE JOINT SELECT TASK FORCE ON THE CHANGING FAMILY

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PREFACE

The California Legislature established the Joint Select Task Force on the Changing Family in September, 1987. It was charged with studying the social, economic, and demographic trends affecting California's families, assessing the significance of those trends for public policy, and recommending to the Legislature and the public policies that will better meet the needs of today's families.

During its three-year tenure, the Task Force held hearings and public meetings in cities across the state, received testimony from a wide range of experts, and listened to the concerns of many kinds of families. The findings and recommendations of the Task Force are reflected in several publications. **Planning a Family Policy for California,** the first year report of the Task Force, outlined major trends affecting the state's families and the inadequacies of our current policies. That report has been supplemented by several subsequent reports, including **Falling Through the Safety Net: The Health Care Crisis and California's Families, Housing California's Families: The End of the American Dream?** and **Families and Adolescents: Dealing with Today's Realities.**

This report, **Families and Substance Abuse: The Case for A Comprehensive Approach**, reflects the specific concerns of the Task Force regarding a topic much on the public agenda. It is not intended as scholarly research, but rather as a presentation of issues and recommendations intended to contribute to the public discussion. The Task Force hopes **Families and Substance Abuse** will stimulate debate, contribute to public awareness, and motivate the Legislature and citizens of the state to address these issues of vital concern to California's families. The Task Force welcomes comments as part of its ongoing effort to respond to public input and promote the health and stability of the state's families.

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EXECUTIVE SUMMARY

I. Ending drug abuse is high on the public agenda at the federal level, the state level, and in local communities. But according to the findings of the Joint Select Task Force on the Changing Family, an important element - perhaps the most important element - in the discussion of ending substance abuse is notably absent: the role of the family.

Substance abuse is a family disease. Not only does one family member's addiction disrupt the entire family unit, but family characteristics are instrumental - in some cases, pivotal - in the development of substance abuse and addiction patterns. Moreover, substance abuse tends to be cyclical, repeating from one generation to the next.

Anti-drug strategies that do not recognize and address the role of the family fail to respond adequately to the scope of the problem.

II. Of the public resources dedicated to fighting drug abuse and addiction, a disproportionate amount flows into law enforcement. The results are evident in soaring arrest rates of both adults and children. The majority of those who end up in prison have substantial histories of drug and alcohol use. However, due to the lack of treatment and rehabilitation in California's prison system, they are unlikely to change their use patterns or their lifestyle upon their release.

Though substance abuse cuts across all class and cultural lines, minority and low income families experience disproportionate harm. Most of those filling prisons and jails as the result of stepped up law enforcement are people of color, in spite of the fact that minorities have lower overall drug and alcohol usage rates than whites. The criminalization of minority communities is especially disconcerting from the point of view of the family: young minorities who are already only marginally employed will leave prison with even less chance of ever supporting a family.

III. Alcoholics and addicts who are motivated to seek help and have the financial means to do so are usually able to find assistance. But the barriers are high for most families. Standard twenty-eight day treatment programs range from $5000 to $18,000. Waiting lists for subsidized programs are long;

many families lack health insurance that covers treatment; and many insurance policies discourage substance abuse treatment in the interest of cost containment. Increasingly, it appears that cultural barriers also exist. Only recently has serious attention been paid to the development of treatment modalities that are appropriate to the needs of California's culturally diverse populations.

Funding formulas - whether private or public - are generally based on individual "slots," discouraging a treatment approach that includes the whole family. Treatment programs also seldom collaborate sufficiently with other services that are critical to long-term recovery, such as vocational rehabilitation and job placement.

IV. The growing population of substance-exposed mothers and babies demonstrates the tragic deficiencies in California's current approach to substance abuse: the lack of accessible treatment; inadequate attention to the needs of the whole family; the use of law enforcement procedures that criminalize the addict rather than heal the family; and administrative and financial barriers that obstruct the development of inter-agency collaboration and culturally appropriate approaches.

Drug addicted mothers, like all addicts, suffer a disease for which they need treatment. The gestation and birth of a child represents an ideal time to treat an addicted mother; most new mothers are highly motivated to make a clean start and provide as best they can for their baby. However, treatment programs for women, especially pregnant and parenting women are few. An addicted mother is much more likely to be referred to the courts and have her child taken away than she is to receive help in overcoming her addiction and building a decent life for her family.

V. The corporate sector has joined attempts to reduce addiction, especially among employees. Managers have found that in the long run, treating substance abuse problems is more cost effective than replacing addicted employees. The most common form of workplace help is provided through the counseling and referral services of employee assistance programs. Studies have proven EAP's to be a cost effective approach. However, employers, too, face the obstacles of high costs and a society that still places too little emphasis on meaningful treatment and prevention.

VI. As prevention strategies have evolved over the last three decades, the most popular have focused on anti-drug curricula for the schools. Evaluations of school-based programs have been mixed to disappointing. Too few prevention resources have been devoted to reaching young people's families - the most influential force in their lives. For the highest risk families, where substance abuse is already prevalent or family interactions are particularly troubled, prevention must take the form of identification and early intervention. Cooperative relationships among the many agencies with which troubled families have contact - the judicial system, child protective services, school authorities, the police - are the key to early problem identification; however, only if services are available to assist the family, does early identification make a difference.

VII. Many communities have begun to develop coordinated strategies, recognizing that substance abuse is a multi-dimensional problem and requires a multi-faceted approach. A strong community response often requires grass roots activity that develops the community's capacity for self-help. Here, again, cooperation across agency lines - from the police department to the public health department - provides the foundation from which local solutions can grow.

VIII. Prevention efforts in many communities are seriously undermined by the ubiquitous advertising of tobacco and alcohol. Advanced advertising techniques that promote the use of legal drugs often target various groups, including women, minorities, and youth, who are most likely to be struggling with problems of poor self-image. Often ads imply that sexual prowess, adventure, or financial success are associated with the use of alcohol or cigarettes. Minority communities are particularly hard hit by advertising campaigns, with tobacco and alcohol products dominating outdoor billboards in most inner-city neighborhoods.

IX. As a society, we pay for substance abuse in numerous ways - alcohol-related traffic deaths and injuries, illness due to cigarettes, babies born disabled for life because of drug exposure, the loss of workplace productivity, and huge law enforcement costs. To date, however, we are paying too little to address substance abuse in the most meaningful way - through effective prevention, early intervention, and comprehensive treatment. Increased funding is at the heart of the solution,

moneys that will be earmarked for agencies that treat and heal addicts and their families.

In accordance with the suggestion of former U.S. Surgeon General C. Everett Koop, who encouraged states to pay for substance abuse problems by taxing the substances that cause them, the Joint Select Task Force on the Changing Family recommends that the Legislature move immediately to increase state taxes on alcoholic beverages, specifically earmarking new funds raised for the prevention and treatment of substance abuse in California.

INTRODUCTION

Of all the problems families face, one of the most debilitating is the chemical addiction of a family member. Addiction knows no color or class: substance abuse and addiction are experienced by families of every social, economic, and ethnic background.

One member's addiction poses a threat to the well-being of the entire family. Whether parent or child, addiction to alcohol, illicit drugs, or other chemical substances inevitably interferes with the addict's ability to participate as a fully functional member of the family.

Families are victimized by addiction, but they also play a role in its development. Family patterns are instrumental in people's attitude toward drugs and alcohol and the likelihood that they will become abusers. Likewise, family involvement is often pivotal to successful prevention and treatment.

Yet, of the millions of dollars spent annually on eradication of the drug problem, only a pittance goes toward involving and assisting families. Of the meager help that is available, little reaches low income and minority families; they suffer the most from current practices that favor punishment over recovery.

In this report, the Joint Select Task Force on the Changing Family looks at a variety of issues related to families and drug abuse. It concludes that California must forge a drug policy that recognizes the key role of families in prevention, intervention, and treatment of substance abuse, and ensure that all families have access to the help they need.

THE FAMILIAL NATURE OF SUBSTANCE ABUSE

Behind the headline-grabbing statistics that characterize the current war on drugs - and largely untouched by the millions of dollars spent annually on drug control - is the personal suffering of thousands of families who cope daily with the reality of addiction.

Substance abuse by a family member - parent or child - escalates family crises and increases stress on family roles and functions. It inhibits honest communication, threatens a

family's economic stability, and spawns coping mechanisms that run the gamut from complete denial to an unrealistic sense of responsibility for the problem. Children growing up with an addicted parent often experience their home as a battle field, never knowing what to expect. In the words of Mary Lou Ragghianti, Director of the Alcohol Council of Marin County, whose mother was an alcoholic:

> "Think about what it must be like to never know what to expect when you get home from school or get up in the morning. Will she be drunk? Will there be any food in the house? Will they have another fight tonight? Will anyone show up at my game - or even worse, what if they show up drunk at my game? ...The alcoholic household leaves emotional scars that can last a lifetime..."[1]

Statistics show high correlations between substance abuse and other abusive family behavior. Fifty-five percent of all family violence occurs in alcoholic homes. Incest is twice as likely among daughters of alcoholics as among their peers. Seventy percent of children of alcoholics develop some compulsive behavior including alcoholism, drug abuse, or eating disorders.[2]

The least powerful family members, usually children, develop a variety of responses to protect themselves against the disruption and stress caused by the addiction - often at great cost to their own psychological growth. And children of addicted parents are at high risk of becoming substance abusers themselves.

- The presence of an alcoholic family member nearly doubles their risk that a male child will abuse alcohol or other drugs. If that alcoholic is the boy's father, the likelihood increases nine-fold.[3]

- Poor family management, inconsistent rules, lax supervision, excessive discipline, constant criticism, and negative communication patterns are also highly correlated with a child's future drug abuse.[4]

Children learn from their parents about the appropriate and inappropriate use of chemical substances just as they learn about other aspects of life. Parents who consistently turn to alcohol or drugs for "help" in coping with stress not only demonstrate drug use to their children, but probably also fail

to teach them appropriate ways to deal with life's difficulties.

An analysis of the role of the family is even more complex from the perspective of treatment professionals. Therapists commonly find that families tend to encourage or sustain a member's substance abuse because symptoms of the abuse serve a variety of functions in the family system, like drawing attention away from other problems, or precipitating "catastrophes" that unify the rest of the family.

Whatever the dynamic that evolves as families deal with and participate in a member's addiction, everyone is inevitably affected, and all often become locked into roles and patterns that are very resistant to change. Therefore, treatment which focuses solely on the individual addict is jeopardized when he or she returns to a family system that has not changed; the pressures to participate in the old patterns and systems remain strong.

To ignore the family in approaches to prevention and treatment of substance abuse is to ignore a powerful and seminal force. Unfortunately, most current policies overlook or even undermine families in the rush to "eradicate" the drug problem.

RECOMMENDATION

Require the State Department of Alcohol and Drug Programs and each individual county to include a focus on families in their funding priorities.

CURRENT POLICIES: INCREASED SPENDING WITH DUBIOUS RESULTS

California will spend more than $1 billion on drug control efforts this year, with nearly 70 percent earmarked for law enforcement. Local governments will spend close to another $2 billion, also primarily for enforcement of drug control laws. The state's anti-drug spending is fueled largely by federal priorities where the war on drugs has assumed increasing importance in recent years. The Anti-Drug Abuse Act of 1986 raised the federal appropriations for drug control to nearly $4 billion, which was increased yet again in 1988 by $1.3 billion.

Law enforcement - from local to international efforts - has consistently consumed the bulk of federal anti-drug moneys. Most recently, the Bush Administration launched its National Drug Control Strategy, a proposal to spend $7.9 billion in 1990, 73 percent on law enforcement and 27 percent on education and treatment activities.[5]

In California, escalating expenditures on law enforcement are evident in unprecedented arrest rates, pressure on the court system, and overflowing prisons.

- Felony arrests for drug law violations have more than doubled in the last five years, from fewer than 80,000 in 1983 to 170,000 in 1989.[6] 1988 alone saw a 22.2 percent increase in the rate of adults arrested for drug law violations and a 65 percent increase in the rate of juveniles arrested.[7] Drug-related commitments to the Department of Corrections rose from 2,007 in 1983 to 7,971 in 1987 - a 297 percent increase.

Those who are arrested range from addicts, who commit criminal acts primarily to maintain their own habit, to the "entrepreneurs" of the drug world, sellers who are disdainful of users but not of the money that can be made by selling. The bulk of those who end up in prison, however, have substantial histories of drug and alcohol use.

- Seventy-six percent of new felon admissions to the California Department of Corrections in 1988 had a history of substance abuse.[8]

- The California Youth Authority estimates that 85 percent of the youthful offenders committed to the Youth Authority are involved in drug or alcohol abuse.[9]

These abusers, regardless of their history of addiction, are unlikely to find help. Few prisons provide systematic treatment, and even long-standing successful prison-based programs are shrinking as their funding base dwindles.

> The Civil Addict Program serves addicted felons at the California Rehabilitation Center in Norco. It offers a range of treatment and rehabilitation services during incarceration and parole, including vocational and academic education, self-help groups, and work assignments. A 25-year follow-up evaluation showed that, for

those inmates who completed the CAP program, the percentage of time spent committing crimes dropped from 40 percent to 17 percent. However, in spite of its proven benefits, funding has dropped, even as the need has grown.

The failure to treat addiction in prisons flies in the face of common sense and compelling research. It is also a tremendous disservice to the prisoners' families - children, spouses, parents - who await their release.

MINORITY FAMILIES BEAR DISPROPORTIONATE BURDEN

Sadly, most of those who are filling - and overfilling - prisons and juvenile halls as the result of stepped up drug enforcement are people of color.

- A national study by the Washington D.C.-based Sentencing Project found that one out of four African American men in his 20's in the United States is either in jail, in prison, on parole, or on probation. The same is true of only one in 17 white men, even though African Americans account for only 12 percent of the nation's substance use.[10]

This is particularly ironic, given that African Americans - and minorities in general - have lower drug usage rates than whites overall.

- A 1989 survey by the National Parents' Resource Institute for Drug Education (PRIDE) found that white teenagers are more likely to use drugs and alcohol than their African American counterparts. The difference between races is greatest when affluent white children of highly educated parents are compared with African American children from poor families. Among high school students, 24 percent of the white students reported they had used marijuana within the past year, compared with 13 percent of African American students. African American students were almost twice as likely to report they could readily obtain cocaine, but white students at all grade levels were more likely to say they had actually used it.[11]

- In every age group, African Americans and Latinos show a slightly lower level of drug use than do whites.[12]

Nonetheless minorities continue to suffer graver effects than whites from the presence of drugs in their households and their communities. Not only are they jailed more often for their involvement with drugs and alcohol, but they are more likely to live in low income areas where drug sales provide a vigorous - and disruptive - source of economic activity.

- One Oakland study found communities where nine out of ten adults and eight out of ten youths were knowledgeable about what drugs were currently being sold on the streets. Of those who were aware of drug-related activities, 90 percent of the adults and 91 percent of the children witnessed it on a daily basis.[13]

These low income communities also bear the brunt of the violence associated with illegal drug sales - a violence over turf that is reminiscent of Mafia wars of an earlier era, but more dangerous because of today's easy access to high powered weapons and the larger number of traffickers vying for a share of the drug market.

Disproportionate law enforcement activities and arrest rates in minority communities are partly the result of community demand, because drug sales are so closely associated with violence in many neighborhoods, and partly the result of the pressure to show results. As Commander Charles Ramsey, supervisor of Chicago's Police Narcotics Division, told the L.A. Times,

> "There's as much cocaine in the Sears Tower or in the stock exchange as there is in the black community. But those guys are harder to catch...and there's not the violence associated with it... But the guy standing on the corner, he's almost got a sign on his back. These guys are just arrestable."[14]

Low income sellers are likely to receive stiffer sentences as well. Under new federal statutes, a person convicted of selling five or more grams of crack cocaine, valued at about $125, is to receive a mandatory prison sentence of five years. To get an equivalent sentence, someone would have to sell 500 grams of powdered cocaine worth $50,000. Crack is prevalent in low income and minority neighborhoods, while the powdered version of the drug is found among higher income users.

The criminalization of minority communities as a result of the war on drugs is especially disconcerting from the point of view

of the family: a young African American man or woman who is already only marginally employable will leave prison with even less chance of ever supporting a family.

HELP FOR THE LUCKY: TREATMENT OPTIONS IN CALIFORNIA

Alcoholics and addicts who are motivated to seek help and have the financial means to do so usually find some sort of assistance. There is no dearth of treatment options for those with money. According to the National Institute on Drug Abuse, the number of treatment centers in the United States grew by 80 percent from 1982 to 1987. Between 1978 and 1984, the number of private centers treating alcoholism quadrupled, and the number of beds in private hospitals used for the treatment of addiction quintupled.[15] But for most families, the barriers to admittance remain high.

- A typical 28-day in-hospital program costs $15,000 to $18,000.

- A 28-day non-hospital residential program generally costs $5000 to $6000, still a significant cost to most families.

Even families with comprehensive health insurance have problems getting coverage for the treatment of addiction. Because of its expense, many insurance companies and health care systems disallow or discourage residential treatment. According to Doug McGuire, Executive Director of the Labor Assistance Program of the Los Angeles County Federation of Labor, many employers contract with consultants to manage their company's heath care costs. In an effort to keep costs down, they tend to underestimate the seriousness of an employee's problem, effectively preventing him or her from obtaining treatment services. Health maintenance organizations (HMO's), in a similar effort to rein in costs, also discourage expensive residential treatment. According to McGuire, California's largest HMO, Kaiser Permanente, has a particularly problematic record regarding substance abuse treatment, generally making only out-patient treatment available to its members.[16]

Publicly-funded programs in California offer a sliding-scale payment structure, based on income, but they are beset by long waiting lists.

- A baseline survey taken on June 30, 1989, found a waiting list for publicly funded treatment of 7587 people. More than half were IV drug users - a group placed on high priority for admittance because of the added risk of contracting the AIDS virus. Nearly 86 percent on the list had waited more than seven days. These numbers do not reflect the individuals turned away altogether, some 4013 in 1989.[17]

The longest waiting lists are for the most intensive long term residential programs. These programs, when surveyed, were at 90 percent capacity, though most treatment providers generally consider 85 percent to be full. Short term detox programs, both residential and out-patient, were at 100.5 percent capacity. Ironically, because many publicly funded programs also serve private patients, they may have empty space even while they maintain a waiting list; those on the waiting list simply cannot afford the private slots. Among the clients relying on publicly-funded programs, only three percent had access to health insurance at the time of the 1989 survey.[18]

Many treatment professionals favor long-term residential treatment - six months to two years - which allows substance abusers to get away from the environment that supported their addicted behavior. Halfway houses and other supervised group living arrangements can play a significant role in the road to recovery, drawing on community-based self-help resources like Alcoholics Anonymous or Cocaine Anonymous. They provide a much less costly alternative to institutional living, while assuring a supportive drug-free environment. But these facilities, too, are limited and burdened by long waiting lists. They also are not appropriate for everyone. For many people with jobs and children, conveniently located, intensive, out-patient treatment options are essential.

Throughout the range of treatment programs, very few include a specific focus on the client's family. Funding formulas - whether private or public - are generally based on individual "slots," discouraging family-group treatment, even though treatment professionals agree that working with the family is often necessary to address many aspects of the disease. Because a parent's addiction places his or her children at high risk of becoming a substance abuser as well, attention to the children is particularly important.

Finally, recovery rates point to another principle underlying successful treatment: clients who are most likely to be successfully treated are those with regular work. According to Dr. Charles Schuster, Director of the National Institute on Drug Abuse, "The best predictor of success is whether the addict has a job." This points to the importance of vocational rehabilitation and stabilization as a component of substance abuse treatment. Again, few programs include such a focus; job training and placement programs are seldom coordinated with drug treatment programs, even though they both may deal with exactly the same clientele.

CULTURAL ISSUES IN TREATMENT

Traditionally, therapy for alcoholism and drug addiction treated all addicts alike, regardless of their ethnic or cultural backgrounds. Today, however, professionals are beginning to understand that cultural differences may provide a key to appropriate intervention and treatment modalities.

Recent studies, for instance, have found that the children of people who emigrated from other countries have higher addiction rates than other children. First generation immigrant children have to cope with the dissonance between the "old world" culture, language, and rules of their parents and the dominant American mores which pull them in another direction. Not only do these families suffer a generation gap, but the two generations represent wholly different cultures. Successful treatment programs recognize and address this added dimension of stress in clients' lives.

Common characteristics are also found among substance abusers within the gay community. Forced by societal discrimination to hide their sexuality from friends and colleagues, over the years the gay community developed a social subculture - places to meet other gay individuals and temporarily let their guard down - that often found a home in bars or cocktail lounges, environments that in themselves encourage excessive drinking. At the same time, the intense personal pressure felt by gay individuals to deny their sexual feelings - in fact, often to deny much of who they are - contributes to a high rate of drug usage to deaden painful emotions and release inhibitions, giving a gay person "permission" to be him or herself. For many gays, rejection by their families is a contributing element in their substance abuse; similarly, family reunifica-

tion can be part of the solution. Treatment professionals have taken these factors into consideration in developing programs specifically for gay and lesbian addicts.

Similarly, culturally specific programs for American Indians, African Americans, Hispanics, and other minority groups acknowledge and validate the experience of people who not only must face their addiction, but must cope with the reality of inequality and discrimination in their lives.

An Atlanta-based organization called Coalesce offers services for African American patients in several Atlanta-area hospitals. Key to the therapy offered by Coalesce are sessions directed at discovering the extent to which a client's experience as an African American influences his or her addiction and recovery. Coalesce therapists find that clients are far more willing to discuss sensitive issues if they are with others with whom they feel an affinity. One of Coalesce's founders, Kenneth Beverly, tells of a client who had been unsuccessfully treated in standard programs, but seemed to make progress after Coalesce got him to talk about having been raped in prison. In Beverly's words, "Incest, homosexuality? Most blacks aren't going to bring those issues up around white people."[19]

In San Francisco, Asian American Recovery Services, Inc. addresses the needs of Asian American clients through sensitivity to their specific cultural backgrounds. For example, one of its projects, the Asian Youth Substance Abuse Project, places treatment and prevention personnel in six different Asian youth agencies, each of which serves a particular Asian community. These new staff members draw on the understanding and expertise of the long-time staff in each agency to ensure that the prevention and treatment services address the unique cultural characteristics of that neighborhood. Treatment modalities vary from one community to another, depending on how westernized a particular community is, or how recently the bulk of the population has arrived in the United States. By bringing all the substance abuse staff together periodically for training, staff can share experiences, benefit from one another's perspective, and become more sensitive to the cultural differences among the various Asian populations being served.

A great deal is yet to be learned about appropriate treatment for different cultural groups. In critiquing current approaches to drug problems in Oakland's African American community, the Institute for the Advanced Study of Black Family Life and Culture found, "Many of the assumptions about treatment (i.e. [the] individual as the target of intervention, what constitutes a serious ailment, the boundaries of specialization, [the] time necessary to affect change, etc.) have not been measured against the experiences of African American people."[20] Only through a fuller understanding of cultural characteristics and a great deal of experimentation can appropriate treatment modalities be developed.

RECOMMENDATIONS

Increase substance abuse treatment options for individual abusers and their families.

- Vastly increase the number of spaces available for residential and out-patient treatment, establishing a state goal of treatment on demand for any chemically dependent person, through the following means:

Encourage the development of non-hospital residential treatment programs which are less expensive than hospital programs.

Encourage the development of alternatives to traditional treatment, such as day treatment and out-patient treatment.

Ensure that plans to extend health insurance coverage to greater portions of the population include detoxification and therapeutic treatment for chemical addiction.

Ensure that every county, including rural counties, provides an accessible, culturally relevant continuum of services.

- Ensure that treatment programs include a family-oriented perspective with services or referrals for family members of the primary client. In providing these services, recognize the diversity of families and do not exclude nontraditional families.

- Remove barriers that prevent inter-agency cooperation.

- Establish coordination between the State Department of Alcohol and Drug Programs and the State Department of Rehabilitation. Include vocational training and rehabilitation as part of substance abuse treatment programs.

- Encourage research and development of culturally appropriate treatment modalities to meet the needs of minority communities.

- Establish drug treatment services within all state and county correctional facilities. When feasible, offer support and therapy groups for prisoners' families.

SUBSTANCE ABUSE AND THE WORKPLACE

The impact of alcohol and other drugs in the workplace is striking.

- Current information indicates that approximately 12 percent of America's 11.4 million workers are addicted to alcohol and that 7 percent are addicted to other drugs.[21]

The work-related costs associated with substance abuse are borne both by addicted employees, who stand a strong chance of losing their jobs due to their impaired work, and employers, who pay directly for lost productivity and employee turnover.

- Annual workplace losses attributed to alcohol abuse amount to $54.7 billion per year nationwide.[22]

- Annual workplace losses attributed to use of drugs other than alcohol are estimated at $26 billion.[23]

Absenteeism, tardiness, and deteriorating job performance are the most significant consequences associated with alcohol and other drug problems. Other oft-noted problems include high accident rates, conflicts with supervisors and peers, and work not completed on time.

- Alcohol and other drug abusers are late to work three times more often than workers not abusing alcohol and other drugs.[24]

- Abusers are absent from the job 16 times more often, have 2.5 times as many absences of eight or more days, and use three times the level of sickness benefits.[25]

- Alcohol and other drug abusers are involved in accidents three to four times more often and file five times the number of compensation claims.[26]

The cost and prevalence of substance abuse has convinced increasing numbers of employers of the benefits of providing help to workers with addiction problems. For many, it is simply a matter of "the bottom line." The cost of replacing an employee, including recruitment, training, and productivity loss, or coping with sporadic behavior on the job can be far more expensive than helping him or her overcome a substance abuse problem.

- The average cost to replace a salaried worker is $6,175.[27]

- The average cost to replace an hourly worker is $676.[28]

- To replace a secretary with only one year of experience, typing skills of 60 words per minute, and shorthand of 80 words per minute, costs more than $7,000.[29]

Employee Assistance Programs provide the most common form of employer-sponsored help. EAP's are confidential counseling agencies which employees can call for help with a variety of personal problems. Some employers sponsor their own internal EAP's, while others contract with outside agencies. In some cases employee assistance is provided by labor unions; these are known as labor assistance programs - LAP's.

The range of services these assistance programs provide varies. However, the greatest single reason workers call is for help with substance abuse. The Employee Assistance Professionals Association estimates that 38 percent of a typical EAP caseload is comprised of alcohol and other drug abusers. Most EAP's do not provide direct treatment services; rather, they counsel employees and serve as a trusted and vital link to direct providers.

The McDonnell Douglas Corporation recently completed a study that demonstrates the value of its employee assistance services.[30] MDC has provided EAP's at various work sites since

1970. In 1985, the management called into question the usefulness of the service. Utilization rates were low and the cost effectiveness of the program was unclear. To test the value of employee assistance programs, the company upgraded its EAP service, instituted it at every work site, and commissioned a four-year statistical study which ultimately included more than 20,000 employees.

Employees who used the EAP service for help with alcoholism, chemical dependency, and mental illness were compared to a control group comprised of employees who, according to medical claims, had substance abuse or mental illness problems, but did not turn to the EAP for help. The study then focused on absenteeism, termination, and medical claims as the best objective measures of the financial impact of these conditions.

The four year study proved conclusively that EAP's are beneficial, especially for employees with substance abuse problems. EAP clients incurred significantly lower medical costs - more than $7300 less over a four year period than the control group. This was true even when entire families were part of the treatment process, a practice highly recommended by EAP caseworkers. Absenteeism among EAP clients, though high during the first year when treatment was initiated, dropped far below the rates of the control group in subsequent years. Likewise, termination rates were reduced by 81 percent when employees sought help from the EAP.

McDonnell Douglas did find disturbing evidence that not all treatment is equally effective. EAP clients who received treatment from health maintenance organizations, for instance, fared more poorly than those who were referred to programs covered by traditional health insurance. Similarly, the company found uneven results for employees dependent on illicit drugs and concluded that treatment protocols must be examined carefully to determine the most effective approach for individual employees.

EAP's are not a panacea for substance abuse in the workplace, but they provide a strong starting point for many employees, and can offer much needed support during the recovery process. Yet even with the assistance of an EAP or LAP, if treatment is not readily available, employees and the company suffer. Long waiting lists and inadequate insurance coverage undermine an employer's desire to maintain a healthy, productive workforce. Thus it is in the interest of the business community that

California see an increase in the number of affordable treatment options, and that employers work handin-hand with government in creating an atmosphere that supports treatment and recovery from the illness of addiction.

RECOMMENDATIONS

Encourage business and labor participation in solving substance abuse problems.

- Encourage employers and labor organizations to institute confidential counseling programs to assist employees and union members with personal problems that impair their work, including substance abuse and addiction. Develop joint assistance programs for businesses and employee groups too small to support one of their own.

- Ensure that employee and labor assistance programs offer services to the client's entire family.

- Ensure that employer and labor representatives are part of efforts to plan community-wide substance abuse prevention and treatment strategies.

SUBSTANCE-EXPOSED MOTHERS AND BABIES

One of the most tragic examples of the deficiencies in our current approach to substance abuse and addiction is found in the growing number of substance-exposed babies born each year to chemically addicted mothers. One look at the "drug baby" problem illustrates a whole spectrum of failings: the lack of accessible treatment options; inadequate attention to the needs of the family; the use of law enforcement procedures that criminalize rather then heal the family; and administrative and financial barriers that obstruct the development of approaches that are known to work.

In 1989, the State Department of Alcohol and Drug Programs estimated that, conservatively, 55,000 to 69,000 births annually in California are of infants who were exposed prenatally to alcohol or drugs.[31] Contrary to prevalent stereotypes, drug-exposed babies are not found only in low income, minority

communities. Maternal addiction, like substance abuse in general, cuts across all class and ethnic lines.

- A 1989 study of 715 pregnant women in a Florida county, with demographics not unlike many California counties, found no significant difference in the amount of drug use between poor women at public clinics and higher-income women visiting their own private doctors. The percentage of white patients and African American patients who tested positively for drug or alcohol use was also similar - 15.4 percent for white women and 14.1 for African American women.[32]

The difference lies in reporting procedures: minority women, many of whom are low income and attend public clinics, are nearly 10 times as likely as white women to be reported to authorities for using drugs or alcohol during pregnancy.[33]

Dr. Xylina Bean, a pediatrician and professor at King Drew Medical Center in Los Angeles, estimates that only about half the babies born drug-exposed are included in official statistics because most hospitals only perform toxicity screens on mothers who are considered "high risk" - women who have not received prenatal care, who have reported histories of substance abuse, who arrive at the hospital obviously under the influence of drugs or alcohol, or whose babies show signs of drug withdrawal.[34]

Due to the lack of standardized testing protocols, the remainder go untested and unreported. Dr. Bean's estimate is substantiated by the experience of the University of California, Davis, Medical Center where researchers universally screened everyone and found a 22 percent incidence of drug-exposure, compared with the 9 percent they would have found had they only screened the "high risk" mothers.[35]

The problems of inaccurate identification and reporting of perinatal substance exposure are worth noting for two reasons: first, skewed statistics exacerbate rampant racial stereotyping; and second, without an understanding of the scope of perinatal substance exposure, the development of appropriate prevention and treatment programs is seriously hampered.

EFFECTS OF PRENATAL DRUG EXPOSURE

The issue of perinatal addiction poses especially difficult questions because the consequences of prenatal drug exposure can be dire. At one time it was thought that a fetus was protected from chemical substances in its mother's system by the placenta which separates the baby's blood from its mother's. But in recent years medical research has shown that drugs do indeed cross the placenta. In many cases, chemicals the mother has ingested can be measured at levels in the fetus almost as high as in the mother.

Prenatal substance exposure can result in a range of symptoms afflicting a new baby, from low birth weight to lifelong developmental disabilities and even to death. And it is not just illicit drugs that can hurt a fetus.

Exposure to cigarette smoking - perhaps the most common of harmful addictions - is unequivocally linked to the risk of low birth weight.

- One study of pregnant smokers in Alameda County concluded that substantially fewer low birth weight babies would be born if just cigarette smoking were eliminated during pregnancy. Additionally, researchers have concluded that regular smoking throughout pregnancy increases the risk of pre-term birth, inter-uterine growth retardation, and abruption of the placenta.[36]

More dramatic than the effects of nicotine on the fetus is the exposure of the fetus to persistently heavy drinking, manifested in fetal alcohol exposure (FAE) or, worse, fetal alcohol syndrome (FAS). FAS involves a cluster of physical and behavioral abnormalities. Among the characteristics of an FAS child are growth retardation before and after birth, mental retardation, neural damage that affects the child's behavioral development, and an array of physical aberrations.

- The prevalence of alcohol-related birth defects is just becoming known. The syndrome was only identified in the 1970's and until recently, many physicians were not experienced in recognizing it. In general, experts believe that alcohol related birth defects could occur in as many as 11 out of every 1000 live births. In California, that translates into more than 400 children each year born with serious, alcohol-related birth defects and another 4,000

born with a range of less severe problems that resulted from prenatal alcohol exposure.[37]

The most alarming rise in prenatal substance exposure is among infants born exposed to illicit drugs, especially crack cocaine. Crack babies are often born prematurely, at very low birth weights, and are at high risk of sudden infant death syndrome (SIDS). They often are in great distress, with tremors, extreme irritability, and inordinate sensitivity to the mildest of environmental stimulation. They cry a lot and do not respond well to being held or swaddled. Even experienced caregivers find crack babies extremely difficult to care for. Like FAS children, crack babies continue to show the effects of their prenatal drug exposure as they grow up. Drug exposed toddlers appear to be more impulsive, less goal directed, and less likely to participate in sustained periods of play than other children. We have yet to learn what will happen to these children as they enter school and grow to adulthood.

- In 1981, Martin Luther King-Drew Medical Center in Los Angeles reported 28 infants born to drug-using mothers; by 1987, that number had risen to 300. It is now up to an average of 70 per month, or 15 percent of all births at the hospital. San Francisco General Hospital reports that 12 percent of its total nursery population is now comprised of cocaine-exposed babies. A recent national study of 300 births in 36 hospitals nationwide, serving all economic groups, concluded that at least one in 10 new mothers had used illicit drugs during their pregnancy.[38]

IMPLICATIONS FOR THE FAMILY

No mother wants to deliver a damaged child, but without assistance, she may have little control. An addicted mother suffers from a disease as real as diabetes or mental illness, but typically she lacks the resources and wherewithal to get help.

One study developed this profile of pregnant cocaine abusers:[39]

- Most have a history of physical, sexual or emotional abuse, and had parents who abused drugs or alcohol.

- Most are likely to live with a drug-abusing partner and come from deprived, chaotic environments.

- Like others with the disease of addiction, most pregnant addicts are subject to symptomatic behaviors, including denial and serious impairment in their ability to fulfill responsibilities consistently.

- Most tend not to seek prenatal care because of fears of punishment or reprisal, especially having their children taken away.

A study on women and cocaine currently under way in Oakland and San Francisco is reaching similar conclusions. Bay Area researchers are finding that the women they have interviewed are the victims of endemic poverty, abuse inflicted by men who control the crack trade, and the "drug hunger" caused by their addiction. Contrary to prevalent stereotypes, they are less involved in exchanging sex for drugs than male addicts and do so only as a last resort. Yet, as researcher Sheigla Murphy told the Oakland Tribune, these women "are judged by a double standard not applied to men and are disproportionately blamed for failing the children they are expected to raise single-handedly."[40]

These may not be women who are well prepared to care for and raise a new child, but most are women who love their children and can, with help, become good parents. In fact, the birth of a baby represents the ideal time to treat an addicted mother. Most new mothers are highly motivated to make a clean start and provide the best they can for their infant. Yet, because of the lack of treatment opportunities, if a woman's substance abuse problem is noted at all, it is most likely within a punitive context, by a system that encourages the break-up rather than the preservation and healing of her family.

PUNISHMENT VS. TREATMENT: A CONFLICT IN STRATEGIES

Typically, if hospitals screen for illicit drugs, they refer positive test results to the county welfare department. County social workers then do an assessment to determine whether they can safely return the baby to the mother or whether they should ask the court to place the baby elsewhere. Increasing numbers of infants are being removed from their parent's care.

- In Alameda County, the number of infants referred by hospitals to county child protective services grew eight-fold from September, 1986, to January, 1988.

- In Los Angeles County, in 1981, the courts received petitions asking that 132 substance-exposed babies be placed in out-of-home care; by 1989, that number had increased to 2784.[41]

- Overall, approximately two-thirds of the cases referred by hospitals to welfare departments result in "petitions for dependency" - requests that the child be made a ward of the court. Eighty-five percent of those petitions are granted.[42]

When a baby is removed from its mother, current policy requires the county's child protective services to attempt to re-unify the family as early as possible. Sadly, this policy of family re-unification is more dream than reality for most addicted parents. The more likely scenario is one in which the child is removed from the mother only to enter the revolving door of foster care, never knowing a permanent family of his or her own. A shortage of foster families means many babies remain in institutional care for months on end.

Meantime, the mother may never receive treatment, but instead continue to deliver more drug-exposed babies whom she lacks the resources to care for and who also will ultimately be taken away from her.

A spate of bills has been introduced in recent years calling for strengthened criminal sanctions against women who abuse drugs during their pregnancy. In several cases women have even been prosecuted by local authorities for endangering their fetuses during pregnancy through the use of drugs or alcohol. While criminalizing prenatal substance abuse may add more women to the prison population, it is not likely to address the basic problem of addiction.

- Sybil Brand Institute for Women in Los Angeles, which was built for 800, currently houses close to 2000. Eighty percent of the inmates are mothers, yet Sybil Brand is not tied into any of the health, education, or anti-drug programs that could prevent these women from returning to a life of drug use.[43]

Criminalization - or the fear of criminalization - actually prevents addicted women from seeking help when they become pregnant. Evidence indicates that addicted pregnant women are afraid to go for prenatal care, for fear they will be thrown in jail or have their other children taken away.[44] Even if they try to get help with their addiction, they may succeed in doing little more than getting on a waiting list for the few treatment programs designed for pregnant women.

- According to the state Department of Alcohol and Drug Programs, approximately 5400 women were on waiting lists in May, 1989. The programs designed specifically for pregnant women and women with children were in particularly high demand.[45]

Incurring the escalating costs of locking these women up only depletes resources that could otherwise help them overcome their addiction and build a healthy life for their children.

Addiction, like any other disease that afflicts a pregnant women, must be identified and treated. A toxicity test should be viewed no differently from any other test administered during prenatal care, labor, or delivery: its purpose is to identify potential problems so that health care providers can offer the services necessary to address them. Just as a doctor who finds evidence of diabetes or mental illness in a pregnant woman uses it to refer her to appropriate specialists, the positive results of a toxicity screen should become part of a patient's confidential medical records to assist in her care.

Across the state, a handful of model programs have emerged to address the complex needs of addicted mothers and their children.

The Eden Center, a non-residential treatment program associated with Martin Luther King Hospital in Los Angeles, is founded on evidence that mothers of drug-exposed babies are often eager to work on their drug problem, organize their lives, and maintain custody of their children, but they need help. Eden provides comprehensive services for mothers and their children. Therapy includes drug treatment, health care, life planning, and re-parenting for many of the mothers who never knew true parenting in their own childhoods. Of the 27 women who participated in the Eden program during its first two and a half years, none has yet delivered another drug-exposed infant.

In Oakland, Mandela House provides a rare alternative for a few fortunate families. The program, which relies on grants, some governmental funding, and the tremendous resourcefulness of its director, serves six women and their babies for a 12 to 18-month period. It includes a residential program, drug rehabilitation, child development, career planning, and a range of life skills training. Fifteen to 20 women are turned away for every one that Mandela House can accept.

Key to these programs is keeping the mother and baby together. According to Kathleen West, Program Development Director for Eden, only 25 to 30 percent of drug-exposed babies cannot safely be placed in their mother's care if they have appropriate support and treatment services. But treatment must be comprehensive, coordinated, and geared toward the whole family unit.

Comprehensive programs like Eden and Mandela House must constantly overcome formidable administrative barriers. They rely on funding from a variety of sources and cross the turfs of multiple bureaucracies. For instance, for drug treatment, they receive categorical funds that can only be used to treat the addict. They must find other sources of funding for the program components concerned with children and other family members. Separate funding streams and separate accounting for each component of the program present a bookkeeping nightmare. Licensing regulations differ for programs that serve adults and those that serve children; these differences, too, must be overcome. Timelines of different systems often do not mesh. If the child has been removed from its mother, the judicially--mandated reviews of the mother's ability to take the child back may not correspond with the mother's own recovery process. Meantime, a mother who does not have custody of her children loses her public assistance and her eligibility for Medi-Cal, often her only means to pay for treatment.

Perhaps the most fundamental barrier is simply the lack of money for comprehensive services.

- In Los Angeles County, women comprise nearly 50 percent of the drug population. Annually, nearly 16,000 women are referred by the courts to the county for treatment. However, the county has only 19 treatment programs that are specifically designed for women. Even placing women in co-ed programs is difficult; in total, Los Angeles County

has the capacity for only 3000 clients in out-patient treatment and 700 in residential programs.[46]

As the number of female addicts increases, the likelihood grows that more drug-exposed babies will be born. Putting mothers in jail or breaking up their families is unlikely to cure their addiction or keep them from having future babies. Instead, a woman with drug problems who appears in a doctor's office or in the delivery room should be given the help she needs to overcome her addiction and change her life. That, in the long run, is the most cost-effective, humane, and family-supportive approach.

RECOMMENDATIONS

Provide confidential non-punitive therapy to addicted women who are pregnant or have recently delivered babies.

- Ensure that prenatal care, whether provided privately or publicly, includes education regarding the harm caused by alcohol and drug abuse.

- Develop comprehensive treatment programs for addicted mothers and their children, including chemical dependency treatment, prenatal medical care for women, pediatric care for infants, coordinated social services, and long term follow-up and monitoring. Relax funding constraints to allow more coordination and integration of program services.

- Develop a confidential toxicity screening protocol for health care personnel to use as a diagnostic tool in order to refer mothers and babies to appropriate services.

- Develop a multi-disciplinary assessment tool to determine whether intervention by child protective services is necessary in any case in which health care personnel determine the mother has a serious substance abuse problem. Care should be taken to assure the cultural sensitivity of the assessment instrument and process. The assessment should determine the mother's ability and willingness to protect and care for her child. Results of the assessment should be used to refer the mother and baby to the appropriate treatment and support programs.

PREVENTION STRATEGIES

Schools and communities throughout the state have been inundated in recent years with drug prevention campaigns. From "Just Say No" slogans to elaborate anti-drug school curricula, most prevention activities are premised on the belief that the most effective way to reduce the demand for drugs in our communities is to convince young non-users not to use drugs and youthful experimenters to stop. Accordingly, increasing funds are flowing into prevention activities. School-based strategies are capturing the greatest number of dollars and the most attention by far. At least 75 percent of California's schools have implemented some form of drug prevention curriculum,[47] but experts hold mixed opinions about their effectiveness, questioning whether the children at highest risk are affected by anti-drug curriculum and whether the effects on any children are lasting.

SCHOOL-BASED PREVENTION STRATEGIES

Evolving theories about drug prevention have spawned three generations of curricula.

> The earliest programs, introduced in the 1960's, focused on increasing students' knowledge about the legal and physical ill-effects of drugs, often using "fear arousal techniques" to scare students away from trying or using drugs.

No evaluation of this prevention strategy showed any level of effectiveness. In fact some studies found this approach actually increased drug use. Experts attribute the disappointing results to several factors. First, students fail to believe the scare stories about drugs because too many know from their own experience that the overstatements are not true. Second, knowledge that an activity is risky is not necessarily enough to keep a young person with a youthful sense of invulnerability from participating in it. Third, the conditions that lead to substance abuse and addiction are far more complex than this approach acknowledges.

> During the 1970's, prevention programs emerged that focused on individual "deficiencies" in a young person that might lead him or her to use and abuse drugs. This approach strove to ensure that students had the confidence,

self-esteem, and decision-making skills they needed to resist the pressure to use drugs. It relied upon classroom activities designed to build communications and problem-solving abilities and tried to help students clarify their values and goals.

This strategy also failed to prove itself in evaluation studies. The most thorough study was done by the National Institute on Drug Abuse in Napa, California, where follow-up studies showed no overall effect on drug use, attitudes, or academic achievement. The only positive finding was a short - term effect some programs had on girls' use of drugs and cigarettes.

More recently a new generation of substance abuse prevention programs has emerged that is based on the "social influence model." This approach assumes that peers, family, and the media hold the greatest sway over a young person's decision to use cigarettes, drugs, or alcohol. It attempts to make students aware of that influence and teach them to resist the pressure, subtle or overt, to use drugs.

The RAND Corporation recently tested this approach with seventh and eighth graders in California and Oregon. Project ALERT (Adolescent Learning Experiences in Resistance Training) focused on preventing or reducing the use of "gateway drugs" - alcohol, cigarettes, and marijuana - with a curriculum of eight weekly lessons for seventh graders and three booster sessions during the eighth grade.

According to RAND's findings, the project successfully lessened the use by both minority and white students of cigarettes and marijuana. However, Project ALERT was less successful in preventing alcohol use. By the eighth grade, half the students in both the control group and the participant group had tried alcohol, and drinking continued to rise about equally among all the groups.

The alcohol findings corroborate a common-sense observation: messages outside the school - at home and in the community - exert significant bearing on the absorption of anti-drug messages at school. As the RAND researchers noted, prevailing opinion has shifted against cigarettes and marijuana, but it remains mixed on alcohol. This no doubt influences the

students' receptivity to anti-drug and cigarette messages, but undermines their openness to anti-alcohol information.[48]

While school-based programs may be improving, their track record - from poor to mixed - suggests that a school-based program alone is not enough to determine whether students will use drugs and alcohol, much less whether they will become problem drug users later in life.

PARENT AND FAMILY EDUCATION

The focus on school-based curriculum development over the last 30 years has diverted attention away from the most influential force in young people's lives - their family. Patterns and interactions within the family are the most important predictors of whether a young person will become seriously involved in substance abuse. Yet only a handful of programs are devoted to working with the family in a preventive manner.

Comparisons of drug-using families with non-using or low- using families show that non- and low-using families are better at problem-solving, more effective in their communication, and less authoritarian. In these families parents tend to hold more realistic expectations of their children and children tend to perceive more love from their parents, especially their fathers.[49] A troubled, disorganized, or fragmented family life is an undisputed factor in placing youths at risk of substance abuse. Programs that encourage healthy family interactions and cohesion may ultimately be the most effective approach to substance abuse prevention.

Family-oriented prevention models generally emphasize wellness and competence rather than deficiencies. They attempt to provide families with the tools they need to establish health--promoting interactions. Various evaluations have found that even with drug abusing parents, effective family skills training can lead to improved family communication, decreased behavioral problems in the children, and increased commitment to rejecting alcohol and cigarette use.[50]

Behavioral parent training teaches parents appropriate ways of altering their children's problem behavior and increasing positive parent-child interactions. These programs have been used successfully with parents who, in spite of their own

addiction problems, have been able to improve their parenting styles and family interactions.

> The Los Angeles-based Center for the Improvement of Child Caring developed a behavioral parent training program specifically to meet the needs of African American parents. It includes topics of particular concern to African American families and uses a format that is culturally familiar and comfortable for them.

Some programs focus primarily on a family's communication skills and problem-solving abilities. Parent Effectiveness Training (PET) and Systematic Training for Effective Parenting (STEP) are the most well known of these programs. They teach parents through lectures, discussions, and role plays about ways they can improve their interactions with their kids.

Irene Redondo, Executive Director of Project INFO in Whittier, California, uses this model but emphasizes the importance of working with the whole family. As she told the Task Force, "It's not enough just to train parents. You've got to work with the entire family... Children have to know what role they play. They, too, have to accept responsibility for playing a part in the atmosphere of their home."[51]

> Project INFO brings together 15 to 20 families over a seven week period, teaching them communication skills and allowing them to practice, first with non-family members, then within their family group. In recent years Project INFO has begun to offer Spanish-language services. When translating the original curriculum, it became apparent to the Project INFO staff that more than a strict language translation was needed; the program subsequently added classes that address acculturation issues as well.

Unfortunately, as effective as many of these programs may be, recruiting parents and families to participate is often difficult. In some cases, families are referred to programs by teachers, counselors, truant officers, or judges who identify problems such as the early use of drugs or alcohol, dropping grades, truancy, or disciplinary problems. However, most families with substance abuse problems or the potential for problems have no contact with anyone who can suggest useful programs. To reach these families, creative approaches have emerged to facilitate voluntary participation in prevention education.

In Contra Costa County, family support workshops are held at worksites. The Workplace Prevention Program, sponsored by United Way of the Bay Area, invites employees to a series of workshops designed to provide practical tools for improving family communication and conflict resolution. Five hour-long sessions focus on preventing substance abuse and violence among young people. They also acquaint parents and other family members with family support resources available in the local area.

FOCUSED HELP FOR HIGH RISK FAMILIES

Just as youth who are at highest risk of abusing drugs and alcohol are the hardest to influence with prevention programs at school, families who are the most likely to produce substance abusing offspring are the least likely to seek help in preventing such an outcome. The highest risk families - those with one or more parent who is a substance abuser - are especially unlikely to seek family training or other prevention help. For these families, prevention activities are usually dependent upon successful intervention by outside forces.

Intervention might come from police, the courts, child protective services, or other enforcement personnel who are called in because of a particular problem, or it might come from a teacher or principal worried about a child's chronic behavior problems. If these authorities are adequately trained to identify a current or potential substance abuse problem in the family, what would otherwise have been a negative or punitive contact can be transformed into real help for the whole family.

In these cases intervention, prevention, and treatment become one process. But a successful intervention requires a collaborative relationship among agencies and a long term connection to the family.

David Love, Executive Director of Valley Community Counseling in San Joaquin County, often works with families where one member has been court-ordered to undergo treatment for substance abuse or family violence. He maintains that because denial is at the heart of addiction and other family problems, extraordinary measures may be necessary, like leveraging the fear of punishment, to convince a family member to enter a treatment or prevention program. "In a year long program," according to Love, "when someone is there every day, the

therapy begins to work on them, breaking down the denial and forcing them to look differently at their life."[52]

> Valley Community Counseling serves 1500 people weekly in San Joaquin and Tuolumne Counties. Clients have been ordered to undergo treatment for substance abuse, battering, sex offenses, and other related behaviors. In some instances, youth are the offenders, but their entire family is required to participate in the counseling program. In each case, staff believes, punishment alone would be unlikely to address the problem and change a person's - or a family's - long-term behavioral patterns.

The involvement of "enforcers" - police, district attorneys, judges, child protective services, teachers, principals, and other authorities - is especially important because they are often among the first to identify a substance abuser or the troubled child of a substance abusing family. By intervening early, they can ensure that the family receives help before its problems become unmanageable. However, such a strategy can work only if appropriate programs exist to aid the families in need of them.

Currently, California law allows judges to court-order families into treatment/prevention programs under certain conditions. However, few judges use this authority. Many are unaware they have the power, and others do not know of viable treatment options they can rely upon. Successful use of treatment as an alternative to punishment requires better training of judges, the existence of appropriate treatment options, and more interaction between "enforcers" and the treatment community.

COORDINATED COMMUNITY STRATEGIES

Substance abusers do not exist in isolation; they are part of a greater environment that shapes and is shaped by them. Over the past 25 years public health officials have examined this interaction and concluded that, for the most part, people use chemical substances according to the norms and expectations of their environment and cultural background.[53] This suggests an approach to prevention that alters environmental and cultural influences and discourages toleration of heavy levels of substance use.

Increasingly, communities are experimenting with this approach. Through a multi-faceted range of activities, they are trying to change community mores and alter what is considered acceptable behavior. Among the multiple strategies in effect in many California communities:

- Training of community leaders both to act as role models and to establish abuse prevention programs within their particular spheres of influence.

- Citizen involvement in developing regulation of alcohol outlets in order to lessen their density, proximity to schools, and excessive sales in neighborhoods.

- Law enforcement crack downs on drunk drivers, neighborhood drug sales, and establishments that sell alcohol to youth and people who are already inebriated.

- Bartenders and servers training to promote moderate drinking in bars, restaurants, and entertainment establishments.

- Clean and sober self-help groups for all segments of the community - Alcoholics Anonymous for adults and youth, Al-Anon, Parents Who Care, and other groups whose presence in the community will add to community awareness of drug and alcohol problems.

In communities especially hard hit by illegal drug trafficking, changing the atmosphere can be a long, complex process. Increasingly, community organizers believe the answer lies in developing the community's own self-defense mechanisms. They argue that without the community's will and involvement, no amount of policing or outreach will ever totally rid these neighborhoods of drugs. Building a community's capacity for self-help, however, is a painstaking process, one which requires the cooperation of the police department and help from numerous other agencies. It may be necessary to break through thick walls of fear and despair to reach people, and months of outreach may be required to coalesce a group and develop a strategy appropriate to a particular situation. Such a campaign requires everything from increased police presence to the development of economic alternatives to drug sales. Often communities focus special attention on the youth in the neighborhoods with targeted recreational programs, mentorships,

jobs and other economic alternatives to the illicit drug market, and educational enhancement programs.

In one east Oakland community, the members of an inter-denominational church, located in the heart of a crack district, decided to confront the problem directly. With the support of the Oakland police and the assistance of translators to reach the multilingual local population, the Landmark Ministries congregation staged a series of events - neighborhood clean-ups, nighttime flashlight vigils to discourage drug buyers, and block parties - to build a relationship with the area residents. The congregation then organized a neighborhood family association with the goal of reclaiming the outdoors for family use. The church also bought one of five active crack houses in the immediate vicinity, a six-unit apartment building, and has succeeded in doing away with most of the dealing there. For the first time in years, children are again playing outside and the congregation feels it is making progress toward its aim of making the neighborhood uncomfortable for drug dealers, pressuring landlords to stop renting to sellers, and improving the quality of life for the residents.

The City of Berkeley has developed an anti-drug strategy that combines law enforcement with a range of other services to provide prevention, opportunity, intervention, and treatment options for city residents. The police department converted a donated transit district vehicle into a mobile substation which it parks in problem areas, and the city contracted with an agency to assist neighborhood groups in using small claims court to eliminate drug houses. However, realizing law enforcement and the courts are not the sole solution, the city also established a large multi-service program for high risk junior high and high school youth and started numerous after school programs. To reach residents already in trouble with drugs and alcohol, the city enhanced its treatment and intervention capacity with a mental health mobile crisis unit, school-based health clinics, and extensive public education about treatment resources.

It will be important to monitor and evaluate the results of these coordinated community approaches in order to determine their effectiveness. Equally important is the on-going

analysis of the effects of a well-armed opponent who has a long head-start - the advertising industry.

MIXED MESSAGES: ADVERTISING AND DRUGS

In the last decade and a half, the advertising industry has received increased scrutiny for encouraging the use of harmful and addictive substances.

- In 1984 the typical teenager was exposed to about 1000 beer, wine, and liquor ads each year. Popular magazines averaged about a dozen liquor advertisements each month, and network television aired more than 5000 beer commercials per year in programs watched by adolescents.[54]

Instead of diminishing, those figures have grown with new multi-million dollar advertising campaigns for beer, wine, and wine coolers.

Cigarette advertising, no longer allowed on television and radio, dominates billboards and print media. Total cigarette advertising and promotional expenditures in 1984 exceeded $2 billion.[55]

- In 1985, the 100 companies with the highest advertising expenditures included all six major cigarette manufacturers. Of the 100 most heavily advertised products and services that year, eight were cigarette brands, despite the fact they could use only half of the media outlets available because of the ban on broadcast cigarette advertisements.[56]

The alcohol and cigarette industries claim their advertising goal is to promote brand switching and brand loyalty rather than use by non-users. Whether or not that is their intent, studies indicate advertising does encourage increased consumption.[57] Advanced advertising techniques often target various groups, including women, minorities, and youth, who are most likely to be struggling with problems of poor selfimage. Often ads imply that sexual prowess, adventure, or financial success are associated with the use of a particular brand of alcohol or cigarettes. Cigarette advertising is very heavy in magazines with large adolescent readerships, such as Glamour Magazine, Sports Illustrated, and TV Guide.[58]

Cigarette and alcohol advertising and promotional activities, such as sponsoring sports or music events, have increased disproportionately in minority communities. The bulk of alcohol advertising to the African American population is found in magazines, newspapers, and the broadcast media, but in some areas up to 20 percent of alcohol ad moneys are spent on outdoor advertising.[59]

- In the Los Angeles metropolitan area, nearly half the urban billboard ads are concentrated in African American neighborhoods, though African Americans comprise only 15 percent of the population.[60]

- According to one association of urban billboard advertisers, in 1985, over 70 percent of its members' revenues were for advertising directed to the African American community, where alcohol was second only to ads for tobacco products.[61]

The Latino community has been similarly targeted by alcohol and cigarette manufacturers. Adolph Coors declared the 1980's "The Decade of the Hispanic," an advertising campaign that appeared to be joined by other companies who likewise stepped up their focus on the growing Latino population. Spanish-language billboard advertising and alcohol ads broadcast on the growing number of Spanish-language radio stations have permeated the Latino community. Public health officials are especially worried by advertising that targets youths, those showing families where parents are smoking, and others that project images of young, hip smokers and drinkers.[62]

Peter Bell, former Executive Director of the Institute on Black Chemical Abuse, notes the irony of these advertising trends, especially in minority communities where "[f]ar more is spent promoting the use of alcohol than is spent in federal efforts to interdict the flow of illegal drugs."[63]

CULTURAL SENSITIVITY IN PREVENTION ACTIVITIES

The most commonly used and evaluated substance abuse prevention strategies have traditionally targeted a predominantly white heterosexual population. As California becomes ever more culturally diverse, policy-makers and prevention strategists must target minority communities as effectively as the cigarette and alcohol industries have. This will require careful consider-

ation of language and cultural differences. A simple translation may not be adequate; a prevention program must be based on cultural assumptions shared by its audience. If we do not know what those assumptions are, how can we communicate effectively?

School-based prevention programs will not reach youth who have dropped out of school. Parent and family skills training will be ineffective if they are founded on presumptions that do not fit the families attending the training. The ways that families communicate their pain, their beliefs about the causes of their problems, and their expectations of their members, are characteristics deeply connected to the cultures from which they come. When working with first generation immigrant families, a bi-cultural approach may be necessary because the parents and their children may identify with two very different cultures. Further, within ethnic groups - such as those labeled "Hispanic," "Asian," or "American Indian" - are dozens of separate cultures and peoples. A single strategy to reach Hispanics, for examples, may make sense to Mexican Americans, but totally miss the Guatemalan or Salvadoran refugee population.

> The Filipino Early Intervention Project in San Francisco provides bilingual, bicultural services to Filipino youth. It reaches out to young Filipinos who are at risk of substance abuse, many of whom are unemployed high school drop outs. Project staff train peer counselors who work directly with youngsters who are identified as drug or alcohol users. They organize youth support groups and parent support groups. They also give training and educational presentations to Filipino parents, community members, and other service providers. By working with one specific cultural group, the project is learning a great deal about the health, educational, and economic factors that make young Filipinos vulnerable to problems with alcohol and other drugs.

Sensitivity to the diversity of California's population must underlie the development of all our prevention strategies.

RECOMMENDATIONS

Help families to live in an environment that discourages substance abuse and addiction:

- Ban alcohol and cigarette advertising on television, radio, and billboards and disallow business tax write-offs for any other advertising of alcohol and cigarettes.

- Include the dangers of legal drugs as well as illicit drugs in anti-drug educational campaigns.

- Encourage communities to develop local organizing strategies to empower and mobilize residents of drug-infested neighborhoods.

Respect cultural diversity in prevention programs.

- In all prevention programs, promote strong cultural identity and respect for cultural diversity. Develop multicultural prevention materials and curricula for statewide use.

Enhance efforts at identification, early intervention, and support for families experiencing substance abuse problems.

- Increase training of educators, medical professionals, and law enforcement personnel regarding signs of chemical dependency or substance abuse within a family.

- Promote greater use by the courts, schools, and other authorities of treatment in lieu of punishment for identified substance abusers.

- Promote or, where possible, require culturally appropriate family skills training for families where one member has been identified as having a chemical dependency or the family exhibits risk factors for substance abuse.

- Encourage the participation in prevention programs and support groups by children of identified substance abusers.
- Establish regular community-wide discussion, linking local government agencies, schools, community organizations, churches, and the business community in an on-going effort to develop and refine prevention, identification, and intervention strategies appropriate to their community.

THE QUESTION OF MONEY

Addiction and substance abuse result in high costs to families and society. Legal drugs - alcohol and tobacco - are by far the most widely used and costly of the chemical substances considered by the Task Force. However costs associated with illegal drugs continue to climb, and the preventable effects of substance abuse on newborns present potential costs that go well beyond any budget forecasts.

Deaths and illness due to alcohol and cigarettes are first on the list of avoidable and tragic costs.

- During 1987, 45,533 alcohol-related motor vehicle accidents resulted in 2,754 deaths and 68,817 injuries in California alone. Half the people killed and one-fifth of those injured in motor vehicle accidents that year were in accidents that involved alcohol.[64]

- Alcoholism remains the most serious substance abuse problem plaguing businesses. In a typical company, alcohol and drug addicts incur 300 percent more medical expenses than the rest of the employees, lose twice as much worktime as the average, and are five times more likely to be involved in accidents off the job.[65]

Costs associated with illicit drug use not only include the toll taken on individual health and productivity, but soaring costs related to their illegality.

- In 1987, 2,000 people died in California as a direct result of drug abuse. About three-quarters of drug deaths are drug induced; in the remainder, drugs are a contributing factor to suicides, violence, and accidents.[66]

- From 1983 to 1988 California saw a 93 percent increase in the rate of adults arrested for drug law violations and an 87 percent increase in the rate of juveniles arrested.[67]

- California's larger metropolitan courts report that 60 to 65 percent of their criminal caseloads are drug offenses, and another 20 percent are for drug-related crimes.[68]

Both alcohol and illicit drugs contribute to the skyrocketing expense of drug babies.

- A national analysis measured the costs of treatment, rehabilitation, and the lifelong lost productivity for the number of children born with fetal alcohol syndrome (FAS) in 1984 and concluded that the cost over the lifetime of the FAS children born in one year would top $1.6 million.[69]

- The U.S. Department of Health and Human Services estimated that just to get a crack baby ready for school can cost more than $40,000 a year. Educators predict many of these children will need years of special education to overcome their learning disabilities, while their emotional problems may require extensive residential care.[70]

Lost work time and lost jobs, incarceration, serious accidents, chronic illness, long-term medical needs - the myriad personal problems associated with heavy drug use - are all family problems. They threaten family income and destabilize family relationships. They pose problems for employers, government, and business.

However, the question of money goes beyond the rising expenditures associated with addiction and dangerous drug use. It is also a question of <u>how</u> our money is spent. As federal, state, and local drug-related expenditures grow, huge sums are likely to be misspent if we fail to develop a solid understanding of all aspects of the drug problem. It is critical that research and program evaluation continue to further our understanding of the physiological effects of drugs, appropriate treatment modalities, and the effectiveness of prevention and treatment programs.

Finally, to address substance abuse in the most meaningful way - through effective prevention, early intervention, and appropriate treatment - California must be willing to spend sufficient money. Among the ideas to generate new funds to address the drug issue, a proposal by former U.S. Surgeon General C. Everett Koop stands out for its logic and simplicity. Dr. Koop suggested that states pay for substance abuse problems by taxing the substances that cause some of the worst of those problems - beer, wine, and hard liquor.

Currently California's alcohol taxes are among the lowest in the nation. No state taxes wine as lightly as does California, at just one cent per gallon. Only New Jersey taxes beer at a lower rate. Only five states have lower taxes on hard liquor.

A use tax on alcoholic beverages makes sense particularly because it requires a greater payment from the people who drink the most - those whose use presents the highest risk to society. In 1988 California passed a tax on cigarettes which now pays for tobacco prevention services and related public health programs. Likewise, by taxing alcoholic beverages, the state could begin to recoup some of the moneys it spends annually to deal with the costly results of substance abuse.

RECOMMENDATIONS

Utilize funds more effectively by developing a better understanding of appropriate intervention modalities and increasing coordination and integration of services.

- Fund research to determine the physiological effects of drugs and appropriate treatment modalities.
- Fund research to determine the effectiveness of prevention and treatment programs.
- Earmark a percentage of drug assets forfeiture money which is currently going to law enforcement for the expansion of drug treatment programs.

Increase the tax on all alcoholic beverages sold in California, and earmark the moneys generated for prevention and treatment of substance abuse problems.

CONCLUSION

It is the responsibility of government to encourage and facilitate the treatment of addiction as a matter of public health and human well-being. Further, it is government's obligation to promote treatment modalities that are appropriate for all residents, no matter what their cultural or ethnic background. Because substance abuse is familial in nature, treatment and prevention must address the entire family, helping to heal wounds caused during the course of the addiction and teaching skills to avert future abuse of drugs or alcohol.

The Joint Select Task Force on the Changing Family is convinced that only if California establishes a state drug policy that emphasizes the role of the family, is culturally sensitive, and expands treatment options will we meaningfully address the substance abuse problem in our state.

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